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My name is Charlene Harrington and I am a professor of nursing and sociology at the University of California, San Francisco, CA (UCSF). The focus of my remarks today will be on providing consumers with information about nursing homes as a strategy for improving quality. An Internet information system about nursing homes will allow consumers to make choices among the various nursing facilities and to obtain periodic information the quality of care in specific facilities. In the long run, having a consumer information system may encourage facilities to improve the quality of care they deliver in order to be more competitive. An Internet information system will bring poor quality into full public view so that the public will know what is going on behind the closed doors of the nation's nursing homes.

For the past five years, I have been developing a consumer information system for nursing homes, funded by the Agency for Health Care Policy & Research. My colleagues on this consumer information system project are Dr. Joseph Mullan at UCSF, Dr. David Zimmerman at the University of Wisconsin, and Sara Burger, Executive Director of the National Citizens' Coalition for Nursing Home Reform. My recommendations today are based on our research experience and findings from this project.

In July 1998, President Clinton and HCFA officials announced that they would provide a consumer information system on the Internet, as my colleagues and I have long proposed. We were extremely pleased that HCFA has expressed a willingness to develop such as system and we have been working with HCFA officials on an informal basis, using the HCFA On-Line Survey Certification and Reporting System (OSCAR) data.

Deficiency Information

In the fall of l999, HCFA posted the information on federal deficiencies for each nursing home in the US on the Internet under www/Medicare.nursinghome.compare. This Web site information is very popular because it allows the public to call up information on any nursing home in the country to determine every facility's most recent violations of the federal survey and certification regulations. There are 185 federal standards on quality that each nursing home must meet. If a facility fails to meet one of these minimum federal standards, the state surveyors issue a deficiency.

State surveyors rate each deficiency by scope and severity using federal guidelines. HCFA has agreed to add the information about the scope and severity of deficiencies to its Web site system by July, 1999.

The next step in improving the deficiency information is to group the 185 deficiency standards into related and meaningful groups that are more easily understood by the public than a simple listing of all deficiencies. We have proposed that all the deficiencies should be presented under one of eight quality dimensions, based on a factor analysis of the deficiency data that Dr. Joe Mullan and I conducted at UCSF. The first dimension, Quality of Care, includes standards that were all related to providing direct care to residents, for example, residents receiving necessary services to maintain their functional status, or receiving care for pressure sores. The next dimension, Mistreatment, includes standards that refer to behaviors associated with potential abuse, for example, using unnecessary restraints, or involuntary seclusion. The third dimension, Assessment, includes standards referring to facilities' procedures for accurate resident assessment, for example, making comprehensive assessments, and developing comprehensive care plans. The fourth dimension, Residents Rights, includes standards about protecting the right to privacy and confidentiality of personal and clinical records and generally respecting the

dignity of each resident. The fifth dimension, Environment, includes standards such as providing a safe, clean environment, or maintaining effective pest control programs. The sixth dimension, Nutrition, includes standards concerning nutritional policies, such as generally meeting nutritional needs, and providing attractive substitutes for residents who refuse food. The seventh dimension, Pharmacy, includes standards such as being free from use of unnecessary drugs and for providing pharmacy services to meet resident needs. The eighth dimension, Administrative, includes standards that refer to facility training and monitoring of staff, for example, proper maintenance of clinical records, and having regular meetings of a quality assurance committee. HCFA officials state that they plan to improve the presentation and grouping of the deficiency data in the year 2000 after the Y2K problems are resolved.

This information is important to the public because, tragically, many nursing homes do not meet these minimal standards according to the findings by state surveyors. One-fifth of the almost 16,000 nursing facilities received deficiencies for inadequate food sanitation and for the failure to conduct appropriate resident assessments and care plans in l997. 16 percent of facilities failed to prevent accidents and and 15 percent received deficiencies for improper care of pressure sores in 1997. The average facility received 5 deficiencies, but some received as many as 175 deficiencies. It is unfortunate that most families and residents are generally unaware of the numbers of violations that facilities have received. The new HCFA information system makes the deficiency data more accessible to the public.

Enforcement Actions. Some violations are so severe that facilities receive fines for placing the health and safety of residents in jeopardy. In a recent example, when a nursing home resident developed a urinary infection with a high fever, the attending physician was not notified. The resident was finally admitted to a hospital intensive care, unconscious and in critical condition, and died 3 days later. The state found that the nursing and medical care was negligent and that death was entirely preventable. The state must report the specific enforcement actions that it will take against facilities that have violations of the standards such as civil monetary penalties, suspension of admissions, and decertification.

HCFA has not made the information on civil monetary penalties and other enforcement actions available to the public on its information system. In part, states have not been systematic in reporting the enforcement actions. HCFA is trying to ensure that states are fully reporting the enforcement actions in a systematic way, but this reporting is not yet satisfactory to HCFA. HCFA should add all enforcement actions for each facility to its HCFA Web site information system as soon as possible,

Complaint Information. Another concern has been that states have not been systematically investigating complaints about quality. Not only has the investigation of complaints been poor, but the complaint survey reports have not been systematically entered into the OSCAR information system. HCFA reported a new initiative for state agencies to improve the complaint investigation process in March, 1999, and HCFA is now requiring states to improve the reporting of complaint investigations. Within the coming year, HCFA should include the information on complaint investigations on its consumer information system Web site for all nursing homes.

Facility Characteristics

HCFA plans to add new information on facility characteristics to its consumer information system Web site by the end of July 1999. Consumers will be able to select and compare data from 3 facilities at a time with state and national averages. The information should include the name and location of each facility, plus its number of beds, number of residents, average occupancy rate, ownership type (nonprofit, for-profit, or government), whether it is part of a chain, payer sources (Medicare and Medicaid), and whether it has resident and/or family councils. These are all important basic facts that consumers need to know about nursing facilities.

Resident Conditions.

HCFA has agreed to add information about residents from OSCAR to its Web site information system at the end of July 1999. Facilities should be compared on resident characteristics including: the percent of residents who are very dependent or are bedfast (in bed most of the time) and those who have contractures, weight loss, tube feedings, physical restraints, pressure sores, bladder or bowel incontinence, catheters, behavioral problems, and psychotropic drugs. We have created a text description for each specific resident condition to be presented on the HCFA Web site that will explain each resident condition in plain English.

The OSCAR data show that half of nursing home residents are incontinent and almost half are placed on psychotropic drugs that often serve as chemical restraints to keep residents quiet. Most residents are unable to bathe, dress and feed themselves. Many residents have contractures (immobile joints from lack of movement) and pressure ulcers (from unrelieved pressure on the skin). Many have lost weight and some residents are given tube feedings. Good nursing care could prevent and/or reduce most of these widespread problems in nursing homes.

Surprisingly, facilities often vary dramatically in the way they treat residents. In California, only 28% of the 1,400 California nursing homes had 10 percent or less of residents in physical restraints, while many facilities had 25-90 percent or more of residents in restraints in 1997. The information system will show these differences in resident conditions across facilities.

By the Year 2001, HCFA plans to replace the OSCAR resident information with information from the Quality Indicators (QIs) developed by the University of Wisconsin. The 24 QIs are based upon individual resident information collected from the resident assessments that use the Minimum Data Set form. Validation studies were conducted on the QI's and they were found to be reliable and stable. These 24 QI's cover 11 domains of care:

1. Accidents
2. Behavioral & Emotional Patterns
3. Clinical Management
4. Cognitive Functioning
5. Elimination & Continence
6. Infection Control
7. Nutrition & Eating
8. Physical Functioning
9. Psychotropic Drug Use
10. Quality of Life
11. Skin Care

The QI's for each facility will be reported to each state for use in the state survey process as of July 1,1999. State surveyors will evaluate those facilities that have poor quality indicators to determine whether the federal quality standards are being met. Software has recently been deployed, which will enable all survey agencies and nursing homes in the country to run Quality Indicators reports at both the facility and resident levels. The QI's are also being used in internal quality improvement efforts at more than 1000 facilities across the nation. All that remains is the incorporation of the QI's into a consumer information system, but HCFA officials report that they do not expect to finalize this step until the year 2001. HCFA should speed up this process to provide the summary Quality Indicator information for each facility on its Web site to the public next year.

Nurse Staffing Information

We believe that nurse staffing levels are a critical quality indicator and HCFA has agreed. HCFA plans to put the basic staffing information on the system by July 1999. The nurse staffing information on the Web will compare different types of nursing hours per resident day and total nursing hours. This will show that there are real differences across facilities and that this can translate into very different outcomes for residents. To help users maximize the use of the Internet information, specific questions have been developed that users can ask of nursing home staff, residents, and family members.

Our UCSF studies were the first to examine nurse staffing, using the national OSCAR data for all US nursing homes. The average RN time (including nurse administrators) was 42 minutes per resident day, LPN/LVN time was 42 minutes, and nursing assistant time was 126 minutes in 1997. Total average nurse staffing time was 210 minutes or 3.5 hours per resident day in 1997. In other words, there is only 1 RN and 1 LVN for every 34 residents and 1 nursing assistant for every 12 residents per day in the US. If you consider how long it takes to assist individuals with bathing, dressing, eating, toileting, walking, and taking medications, it becomes apparent that the average staff time may not be sufficient to provide good nursing care.

Wide disparities in nurse staffing levels have been found for different types of facilities. Hospital-based nursing homes and skilled nursing facilities that take only Medicare residents have twice as much nursing staff as other facilities. Smaller facilities, non-profit, governmental, and non-chain facilities have significantly higher staffing than their comparison groups. Moreover, some facilities have dangerously low staffing. Twelve percent of US nursing homes had only 1 and 2.5 hours of nursing staff per resident day compared to the national average of 3.5 hours of staff. These data are essential to a consumer information system.

Unfortunately, the OSCAR staffing data are only collected for a two-week time period during the annual survey by state surveyors. Facilities may increase their staffing during the survey, compared with other times of the year, in order to improve facility performance on the survey. HCFA should require facilities to report staffing data on a quarterly basis at the same time the facilities report their resident assessment data on the Minimum Data Set. The staffing should be reported for each 24- hour period during the quarter. The principal rationale is that Medicare is paying nursing facilities based on staff resource requirements to provide care to residents in 44 different categories based on resident characteristics. Since the payment rates are based on staffing, the staffing data are needed to ensure that the services are provided by facilities. Without staffing data, facilities can take advantage of the payment rates without paying for staff to provide the care that is needed. This is an urgent matter that should be addressed by HCFA to ensure that care is provided.

ACCURACY

Information systems must be monitored to ensure accuracy and to prevent errors or falsification of data. Currently, the OSCAR staffing data are not reviewed or audited by the state surveyors. The staffing data should be audited as a part of the regular state surveys of facilities. Whenever there are reports of low staffing or poor quality of care, state surveyors should examine the payroll records of facilities for different time periods prior to the survey, with special attention to staffing on evenings, nights, and holidays. This would allow surveyors to determine whether the facility had sufficient staffing to provide care to its residents and whether the staffing data were reported accurately. HCFA should issue penalties for false and inaccurate OSCAR data to encourage greater accuracy.

INFORMATION MANAGEMENT AND MONITORING

At the present time, HCFA does not have an effective system for information management and monitoring of the OSCAR data system. Having used the OSCAR data from l991-1998, we have found many problems with the data set. The OSCAR data include duplicate facility records and many errors in the total number of beds, the total number of facilities, and the staffing data. Some of these errors can be attributed to facility staff confusion about the instructions for completing the data while other errors may simply be reporting and data entry errors. These problems have been repeatedly pointed out to HCFA over the past five years by myself and other users of the data systems but corrections have not been made.

When facility reports are collected by the surveyors during the annual survey, the surveyors should review the information before entering the data into the OSCAR system, but obviously this does not happen consistently. Once information is entered into the OSCAR system, the state data managers should identify errors and ask facilities to make timely corrections but this is also apparently not done on a systematic basis. The OSCAR data are sent by the state licensing and certification program to the HCFA regional offices and to the HCFA central office. While HCFA staff ensure that the data are computerized, the editing process is not effective in identifying and correcting errors. HCFA has yet to invest in adequate data management and oversight of the OSCAR information system.

HCFA officials state that they plan to revamp and modernize the OSCAR information system in the next few years. Although this is an important step forward, immediate improvement in the day to day management of the data system is needed now that the information is being put on the HCFA Web site.

HCFA may have been unable to develop a system for managing and monitoring its OSCAR system because of lack of resources and because the information system has a low priority. HCFA should give the information system a top priority and that the appropriate resources and management should be allocated to ensure immediate improvement in the OSCAR system.

NEW DATA ELEMENTS NEEDED

In order to make a better consumer information system, new data elements need to be added. In addition to the new staffing data discussed above, I recommend the collection of new data on staff turnover and stability rates, wages and benefits, facility cost data, and ownership data.

Staff Turnover and Stability Rates. Not surprisingly, the average annual turnover rates are 50 to over 100 percent in nursing homes across the US. The 1996 Institute of Medicine report on nurse staffing reviewed the literature on labor shortages and the unstable labor pool for long-term care and the factors contributing to these problems. In addition to overall staff turnover rates, the length of time of employment is also important. A very high turnover rate among a small percentage of employees is less likely to be a problem than moderately higher turnover rates for a large percentage of employees. High turnover rates of administrators and key supervisory personnel are worrisome given the concerns about the caregiving workforce and the vulnerability of many of those receiving long-term care. HCFA should require facilities to report data on turnover rates for the different types of staff categories (i.e. administrators, registered nurses, and nursing assistants) as a part of the quarterly staffing reports. Such information should then be included in a consumer information system.

Wages and Benefits. In the long run, the quality and stability of the nursing home workforce will not be resolved, however, until wages and benefits and working conditions are improved. Wages in nursing homes are 15 percent lower than those in acute care settings and many staff have no health care benefits. The average wages are $6.94 per hour, which is less than the federal poverty level and less than workers

make in the fast food industry and casinos. High wages and benefits build morale and institutional loyalty, so a facility can have excellent staff that will remain for many years. The average staff wages and benefits in each facility are important quality indicators and we recommend that wage and benefit data be added to the HCFA consumer information next year. Wage and benefit data should be obtained from Medicare and Medicaid cost reports.

Facility Cost Information

One important question for consumers is how do facilities spend their resources. Only 36 percent of total US nursing home dollars are spent on nursing staff, 16 percent for indirect care (food and housekeeping) and 3 percent for therapy services. Administrative costs account for a shocking 27 percent of operating expenses. On top of these expenses, many nursing homes have been highly profitable. This explains why some corporate nursing homes are able to have their own jets, the best lobbyists, and the best lawyers available.

The public has a right to know the financial status of the nursing home where their loved ones live or are considering living. This information is available in the Medicare and Medicaid cost reports. HCFA should require that the Medicaid cost reports be standardized and computerized and HCFA should make key elements from the Medicare and Medicaid cost reports available to the public on the HCFA Web site.

Ownership

Finally, 66 percent of the US nursing homes are for-profit, and most of those are publicly-traded corporations. Consumers need to know the owners of the nursing home corporations and if they are a part of a nursing home chain. Some chains have poor reputations while others have reputations for high quality of care. At the present time, the public does not have a source of information about the owners and operators of facilities. Moreover, HCFA itself is unable to track nursing home chains within or across states. If each facility were require to report the name of its parent corporation(s) and its major owners, this would be a big step forward to making companies more accountable for meeting the federal standards of care. The names of all nursing home owners should be collected and made available on the HCFA Web site.

SUMMARY

In closing, the nation's elderly and those with disabilities deserve our respect and honor. They deserve to lead happy and peaceful lives. And they deserve to die touched by kind hands and compassionate words. Information is needed about the quality of nursing home care. This work must continue so that we can ensure that good nursing home care is not a myth. Information is a first step in the quality improvement process. All those individuals in our nation's nursing homes have the right to a high quality of care and a high quality of life and human dignity.

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